

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G736	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER ABILITIES SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 S EARL AVE LAFAYETTE, IN 47905
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: February 25, 26, 29 and March 1, 2016</p> <p>Provider Number: 15G736 Aims Number: 200859310 Facility Number: 005592</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/7/16.</p>	W 0000		
W 0125 Bldg. 00	<p>483.420(a)(3) PROTECTION OF CLIENTS RIGHTS</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process.</p> <p>Based on observation, interview and record review for 1 of 6 clients residing in the facility (#4), the facility failed to ensure the client had the right to due process in regard to his personal clothing kept locked in a living room closet (only</p>	W 0125	In response to W125, the facility failed to ensure the client had the right to due process in regard to his personal clothing kept locked in a living room closet, the restriction has been added to the behavior plan As part of	03/31/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>staff had a key).</p> <p>Findings include:</p> <p>During the observation on 2/25/16 from 4:14p.m to 6:12p.m., at the group home, staff #5 was observed to open a locked closet in the living room and get clothing out. Staff #5 was interviewed on 2/25/16 at 5:31p.m. Staff #5 indicated client #4 had his personal clothing kept locked in the living room closet due to his behavior of shredding his clothing.</p> <p>Review of the record of client #4 was done on 2/29/16 at 1:54p.m. Client #4's 7/29/15 Individual Support Plan (ISP) indicated client #4 had the identified behavior of shredding his clothing. Client #4's ISP did not address the facility practice of locking client #4's clothing in a closet in the living room.</p> <p>Interview of staff #1 on 2/29/16 at 2:00p.m., indicated the facility was locking client #4's personal clothing in the living room closet due to his behavior of shredding clothing. Staff #1 indicated only staff had a key to the closet. Staff #1 indicated client #4's ISP did not include the behavior intervention to lock his clothing in the living room closet.</p> <p>9-3-2(a)</p>		<p>investigation in to the matter and discussion with the Behavior Specialist, this restriction was missed when carried over from prior behavior plan Parents were in agreement of restriction and ISP was updated to note that it was included in plan Client has access to 2 outfits and the rest of clothing is locked due to behavior of shredding QIDP will review past and present Behavior plans when a new one is implemented to ensure nothing is missed Other clients behavior plans were reviewed to ensure nothing missing</p>	

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W 0130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview, the facility failed to ensure privacy during the observed medication pass for 5 of 6 clients residing in the facility (#1, #2, #3, #5, #6), when they received their medication from facility staff.</p> <p>Findings include:</p> <p>An observation was done at the group home on 2/26/16 from 6:14a.m. to 8:18a.m. At 6:19a.m. staff #6 began the medication pass. At 6:27a.m. client #1 was administered his medication while he was in the living room. Staff #6 verbally indicated the medication client #1 was receiving and had client #1 verbally identify the medication and purposes. Client #3 was also in the living room during the med pass to client #1. At 6:54a.m. client #2 received her medication in the living room with clients #1, #3 and #5 in the living room. At 7:08a.m. client #5 received her medication with clients #1, #2 and #3 in</p>	W 0130	<p>In response to W130, the facility failed to ensure privacy during medication pass, the facility has retrained staff and put a chair in the medication area to make the surroundings more comfortable to consumers receiving meds It was also discussed during training with staff that consumers should be encouraged to come to the medication area for privacy Weekly med pass observations will be done by one of the following, QIDP, Nurse, Coordinator or Director to ensure privacy is being given during med pass Reports of the site visits are submitted for review by the leadership team weekly to address any concerns</p>	03/31/2016

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W 0149 Bldg. 00	<p>the living room. At 7:22a.m. client #3 was given her medication at the dining room table during breakfast with clients #1, #2, #4, #5 and #6 at the table. At 7:34a.m. client #6 was given his medication at the dining room table. Staff #6 also took client #6's blood pressure at the dining room table while client #6 was eating breakfast with clients #1, #2, #3, #4 and #5.</p> <p>Staff #1 was interviewed on 2/29/16 at 2:11p.m. Staff #1 indicated the clients should receive their medication and treatments in the designated medication area. Staff #1 indicated facility staff are trained to give medication in privacy. Staff #1 indicated the client medications should not have been passed in the living room and at the dining room table.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview, the facility failed for 2 of 5 incident/investigations reviewed to</p>			W 0149	In response to W149, the facility failed to implement its policy and procedures to prevent client mistreatment (missing client		03/31/2016

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	<p>implement its policy and procedures to prevent client mistreatment (missing client funds) (#2), and to thoroughly investigate and report results to the administrator for an allegation of neglect (#1, #2, #3, #4, #5, #6).</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 2/25/16 at 2:44p.m. and 2/26/16 at 12:30p.m.</p> <p>1. A reportable incident report, dated 9/30/15, indicated client #2 had been found to have \$20.00 missing from her funds entrusted to the facility. The investigation indicated no other clients had missing funds and client #2 was reimbursed the \$20.00. The investigation did not indicate the identified reason for the missing funds and did not have documented staff interviews. The investigation did not indicated the completion date and when the results were reported to the administrator.</p> <p>2. A reportable incident report/investigation on 10/20/15 indicated a facility overnight staff had slept during their shift while clients #1, #2, #3, #4, #5 and #6 were in the group home. The 10/20/15 investigation did not have documented staff and client</p>		<p>funds) and to thoroughly investigate and report results ASI has identified that the process for identifying if there is a financial discrepancy in the consumers accounts needed re-done In the event that a staff finds an error in financials, it is immediately reported the coordinator and an electronic form is completed that goes to the director to ensure the investigation is completed Financials will immediately be reviewed by the agency fiscal department to identify the issue Documentation will be submitted to Director for review</p>	

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	<p>interviews. The investigation did not indicate when the investigation results were reported to the administrator.</p> <p>The facility policy and procedures were reviewed on 2/29/16 at 7:49p.m.</p> <p>The facility's 12/12 policy and procedure entitled "Abuse, Neglect and Exploitation" indicated: the facility "prohibits the abuse, neglect, exploitation and mistreatment of an individual." The policy indicated "Misappropriation of resident Funds or Property" as deliberate misplacement, exploitation, or wrongful, temporary or permanent use a resident's belongings or money without the residents consent. The policy defined neglect as the "failure to provide goods or services necessary to avoid physical harm, mental anguish or mental illness."</p> <p>The facility's 11/13 policy and procedures entitled "Investigating Allegations of Abuse, Neglect, and Exploitation" indicated: "investigations must be completed in 5 working days;" "supporting documentation should include written statements from staff and other witnesses, interview of consumers and any other documentation that is pertinent."</p> <p>Staff #1 was interviewed on 2/29/16 at</p>			

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	2:11p.m. Staff #1 indicated the facility failed to complete a thorough investigation for the 9/30/15 and 10/20/15 investigations. Staff #1 indicated the facility failed to have documented staff and client interviews and documentation of when the investigations were completed and results reported to the administrator. 9-3-2(a)						
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview, the facility failed to thoroughly investigate 2 of 5 incidents/investigations reviewed for abuse, neglect and mistreatment (#1, #2, #3, #4, #5, #6). Findings include: The facility's reportable incident reports were reviewed on 2/25/16 at 2:44p.m. and 2/26/16 at 12:30p.m. 1. A reportable incident report, dated	W 0154	In response to W154, the facility failed to thoroughly investigate incidents for abuse, neglect and mistreatment, ASI has identified that the process for investigating if there is a financial discrepancy in the consumers accounts needed re-done The reporting of the incident and the investigation were not complete In the event that a staff finds an error in financials, it is immediately reported the coordinator and an electronic form is completed that goes to the director to ensure the investigation is completed	03/31/2016			

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W 0156 Bldg. 00	<p>9/30/15, indicated client #2 had been found to have \$20.00 missing from her funds entrusted to the facility. The investigation indicated no other clients had missing funds and client #2 was reimbursed the \$20.00. The investigation did not indicate the identified reason for the missing funds and did not have documented staff interviews.</p> <p>2. A reportable incident report/investigation on 10/20/15 indicated a facility overnight staff had slept during their shift while clients #1, #2, #3, #4, #5 and #6 were in the group home. The 10/20/15 investigation did not have documented staff and client interviews.</p> <p>Staff #1 was interviewed on 2/29/16 at 2:11p.m. Staff #1 indicated it appeared the facility failed to complete thorough investigations for the 9/30/15 missing funds incident and for the 10/20/15 alleged neglect incident. Staff #1 indicated she was not aware of any other documentation for these investigations.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be</p>		<p>Financials will immediately be reviewed by the agency fiscal department to identify the issue. Documentation will be submitted to Director for review. This will ensure a timely and thorough investigation. This issue also existed for allegation of a staff sleeping. The staff was terminated, but the investigation was not complete. The Coordinator did not submit paperwork to the Director covering during a vacation. All processes with investigations have been reviewed to ensure coverage provides a review of investigations.</p>		

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	<p>reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident.</p> <p>Based on record review and interview, the facility failed for 2 of 5 reportable incident investigations reviewed (#1, #2, #3, #4, #5, #6) to ensure reportable incident investigation results were reported to the administrator within five working days.</p> <p>Findings include:</p> <p>The facility's reportable incident reports were reviewed on 2/25/16 at 2:44p.m. and 2/26/16 at 12:30p.m.</p> <p>1. A reportable incident report, dated 9/30/15, indicated client #2 had been found to have \$20.00 missing from her funds entrusted to the facility. The investigation indicated no other clients had missing funds and client #2 was reimbursed the \$20.00. The investigation did not indicate when the results of the investigation were reported to the administrator.</p> <p>2. A reportable incident report/investigation on 10/20/15 indicated a facility overnight staff had allegedly slept during their shift while clients #1, #2, #3, #4, #5 and #6 were in the group home. The 10/20/15</p>	W 0156	<p>In response to W156, the facility failed to thoroughly investigate incidents for abuse, neglect and mistreatment, ASI has identified that the process for investigating if there is a financial discrepancy in the consumers accounts needed re-done The reporting of the incident and the investigation were not complete In the event that a staff finds an error in financials, it is immediately reported the coordinator and an electronic form is completed that goes to the director to ensure the investigation is completed Financials will immediately be reviewed by the agency fiscal department to identify the issue Documentation will be submitted to Director for review This will ensure a timely and thorough investigation This issue also existed for allegation of a staff sleeping The staff was terminated, but the investigation was not complete The Coordinator did not submit paperwork to the Director covering during a vacation All processes with investigations have been reviewed to ensure coverage provides a review of investigations</p>	03/31/2016

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W 0249 Bldg. 00	<p>investigation did not indicate the completion date of the investigation and when the results were reported to the administrator.</p> <p>Staff #1 was interviewed on 2/29/16 at 2:11p.m. Staff #1 indicated it appeared the facility failed to document when the investigation results were reported to the facility administrator. Staff #1 indicated she was not aware of any other documentation for these investigations.</p> <p>9-3-2(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 sampled clients (#2, #3) to ensure the clients' training programs were implemented when opportunities were present.</p> <p>Findings include:</p>	W 0249	In response to W249, the facility failed to ensure clients' training programs were implemented when opportunities were present, ASI identified that staff needed additional training in the areas of clients' training programs Staff were retrained and have been regularly observed implementing clients' training programs Weekly site observations during meals and other programming time will	03/31/2016

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W 0264	<p>An observation was done at the group home on 2/26/16 from 6:14a.m. to 8:18a.m. Client #3 was observed to eat breakfast at 7:14a.m. and to receive her medications at 7:22a.m. Client #3 did not wash her hands prior to eating breakfast and taking her medications. Client #2 ate breakfast at 7:14a.m. Client #2 did not use any communication devices during the meal.</p> <p>Record Review for client #2 was done on 2/26/16 at 2:17p.m. Client #2's 8/19/15 individual support plan (ISP) indicated client #2 had a training program to indicate eat and drink by pointing to her eat and drink cards.</p> <p>Record Review for client #3 was done on 2/26/16 at 2:52p.m. Client #3's 7/1/15 ISP indicated client #3 had a training program to wash her hands with soap prior to consuming her evening meal.</p> <p>Staff #1 was interviewed on 2/29/16 at 2:11p.m. Staff #1 indicated client #2 had a communication goal to use picture cards at her meals and client #3 had a hand washing goal prior to meals. Staff #1 indicated facility staff should have implemented client training programs whenever opportunities were present.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(iii)</p>		<p>be done by one of the following, QIDP, Nurse, Coordinator or Director to ensure clients' programs are being implemented Reports of the site visits are submitted for review by the leadership team weekly to address any concerns Site visits are made to the home 3 times a week and the Coordinator is in the home to observe at least one day a week. Site visit forms are submitted electronically to the team following the visit to immediately address any concerns. The leadership team reviews the site visits weekly as part of quality assurance.</p>				

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Bldg. 00	<p>PROGRAM MONITORING & CHANGE</p> <p>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview, the facility's Human Rights Committee (HRC) failed for 1 of 6 clients (#4) residing in the facility to review restrictive interventions: the facility practice of locking client #4's (only staff had key) clothing in a closet located outside of his bedroom.</p> <p>Findings include:</p> <p>During the observation on 2/25/16 from 4:14p.m to 6:12p.m., at the group home, staff #5 was observed to open a locked closet in the living room and get clothing out. Staff #5 was interviewed on 2/25/16 at 5:31p.m. Staff #5 indicated client #4 had his personal clothing kept locked in the living room closet due to his behavior of shredding his clothing.</p> <p>Review of the record of client #4 was done on 2/29/16 at 1:54p.m. Client #4's 7/29/15 Individual Support Plan (ISP) indicated client #4 had the identified behavior of shredding his clothing. Client</p>	W 0264	In response to W264, the facility HRC failed to review restrictive interventions, the restriction has been added to the behavior plan As part of investigation in to the matter and discussion with the Behavior Specialist, this restriction was missed when carried over from prior behavior plan Parents were in agreement of restriction and ISP was updated to note that it was included in plan Client has access to 2 outfits and the rest of clothing is locked due to behavior of shredding QIDP will review past and present Behavior plans when a new one is implemented to ensure nothing is missed Other clients behavior plans were reviewed to ensure nothing missing	03/31/2016

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W 0289 Bldg. 00	<p>#4's ISP did not address the facility practice of locking client #4's clothing in a closet in the living room.</p> <p>Record review of the facility's HRC reviews from 2/1/15 to 2/29/16 was done on 2/29/16 at 1:58p.m. There was no documentation the HRC had reviewed the facility's restrictive practice of the locking of client #4's personal clothing in a closet in the living room.</p> <p>Interview of staff #1 on 2/29/16 at 2:00p.m. indicated the facility practice of locking client #4's clothing was not identified in his ISP and there was no documentation the behavior intervention had been presented to the facility's HRC during the past year.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, record review and interview, the facility failed for 1 non-sampled client (#4) with a restrictive behavior management plan, to ensure that</p>	W 0289	In response to W289, the facility failed to ensure all interventions for a restrictive behavior were included in the ISP The restriction has been	03/31/2016			

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	<p>all interventions (locked personal clothing) to manage client #4's behaviors were included in the client's individual support plan (ISP).</p> <p>Findings include:</p> <p>During the observation on 2/25/16 from 4:14p.m to 6:12p.m., at the group home, staff #5 was observed to open a locked closet in the living room and get clothing out. Staff #5 was interviewed on 2/25/16 at 5:31p.m. Staff #5 indicated client #4 had his personal clothing kept locked in the living room closet due to his behavior of shredding his clothing.</p> <p>Review of the record of client #4 was done on 2/29/16 at 1:54p.m. Client #4's 7/29/15 ISP indicated client #4 had the identified behavior of shredding his clothing. Client #4's ISP did not address the facility practice of locking client #4's clothing in a closet in the living room.</p> <p>Interview of staff #1 on 2/29/16 at 2:00p.m., indicated the facility was locking client #4's personal clothing in the living room closet due to his behavior of shredding clothing. Staff #1 indicated only staff had a key to the closet. Staff #1 indicated client #4's ISP did not include the behavior intervention to lock his clothing in the living room closet.</p>		<p>added to the behavior plan and ISP As part of investigation in to the matter and discussion with the Behavior Specialist, this restriction was missed when carried over from prior behavior plan Parents were in agreement of restriction and ISP was updated to note that it was included in plan Client has access to 2 outfits and the rest of clothing is locked due to behavior of shredding QIDP will review past and present Behavior plans when a new one is implemented to ensure nothing is missed Other clients behavior plans were reviewed to ensure nothing missing</p>	

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W 0383 Bldg. 00	<p>9-3-5(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview, the facility failed for 6 of 6 clients residing in the group home (#1, #2, #3, #4, #5, #6), to ensure the keys to the drug storage cabinet were inaccessible to unauthorized people.</p> <p>Findings include:</p> <p>An observation at the group home was done on 2/26/16 from 6:14a.m. to 8:18a.m. At 7:45a.m., staff #6 placed the key he had used to unlock the medication storage closet (contained client medications) on a key holder located on the wall in the kitchen. The key holder was mounted on the kitchen wall at a height that was accessible to clients #1, #2, #3, #4, #5 and #6.</p> <p>Staff #4 was interviewed on 2/26/16 at 8:18a.m. (at the group home). Staff #4 indicated the medication closet key was kept on the key holder located on the kitchen wall.</p>			W 0383	<p>In response to W383, the facility failed to ensure keys to the drug storage cabinet were inaccessible to unauthorized people, the facility identified that the keys were being placed with the vehicle keys rather than physically with staff while on shift Staff have been retrained Weekly site observations will be done by one of the following, QIDP, Nurse, Coordinator or Director to ensure all keys are secure Reports of the site visits are submitted for review by the leadership team weekly to address any concerns</p>		03/31/2016

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W 0455 Bldg. 00	<p>Staff #1 was interviewed on 2/29/16 at 2:11p.m. Staff #1 indicated the medication keys should not be left on the key holder in the kitchen. Staff #1 indicated the medication room keys should be kept in a secured place.</p> <p>9-3-6(a)</p> <p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview, for 3 of 3 sampled clients (#1, #2, #3) and 3 additional clients (#4, #5, #6), the facility failed to encourage the clients to wash their hands before meals and during the medication pass.</p> <p>Findings include:</p> <p>An observation was done at the group home on 2/26/16 from 6:14a.m. to 8:18a.m. Staff #6 was observed to pass medication to client #1 at 6:27a.m., client #2 at 6:54a.m., client #5 at 7:08a.m., client #3 at 7:22a.m. and client #6 at 7:34a.m. The clients were not observed to wash their hands prior to the medication pass. Staff #6 did not prompt the clients</p>	W 0455	<p>In response to W455, the facility failed to encourage the clients to wash their hands before meals and during medication pass, the staff have been retrained in prevention, control, and investigation of infection and communicable disease ASI identified that as med passes were not being given in a private space, hand washing was not encouraged before med administration Moving to the private space and having hand sanitizer available was discussed and implemented Weekly site observations will be done by one of the following, QIDP, Nurse, Coordinator or Director to ensure proper procedures are followed for prevention of infection and communicable disease Reports of the site visits</p>	03/31/2016			

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W 0484 Bldg. 00	<p>to wash their hands before the medication pass. At 7:14a.m. clients #1, #2, #3, #4, #5 and #6 were prompted to come to the dining room for breakfast. None of the clients washed their hands before eating breakfast. Staff did not prompt the clients to wash their hands before dining.</p> <p>Interview of staff #1 on 2/29/16 at 2:11p.m. indicated all clients should be washing their hands prior to dining and receiving medication.</p> <p>9-3-7(a)</p> <p>483.480(d)(3) DINING AREAS AND SERVICE</p> <p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation, record review and interview, the facility failed for 2 of 3 sampled clients (#1, #2) to ensure the clients were provided their identified adaptive dining equipment.</p> <p>Findings include:</p> <p>An observation was done at the facility run day program on 2/26/16 from 11:32a.m. to 12:27p.m. At 11:36a.m. clients #1 and #2 were eating lunch. Client #1 had his food (cut up hot dog) in</p>	W 0484	<p>are submitted for review by the leadership team weekly to address any concerns</p> <p>In response to W484, the facility failed to ensure clients were provided their identified adaptive dining equipment, ASI identified that additional training and supplies were needed. Adaptive equipment has been thrown away by other clients' and not reported to supervisors. The implementation of electronic forms to be immediately submitted when supplies are needed is in place Staff were retrained and have been regularly observed providing identified adaptive</p>	03/31/2016

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	<p>a large sized bowl. Client #1 had regular style utensils and a drink in a Styrofoam cup. Client #1 was attempting to scoop up a piece of the hot dog from his bowl. When client #1 was scooping the bowl was moving away from him on the table. Client #2 was custodially fed (by staff) her hot dog and fruit cocktail. Client #2 had regular style utensils. Client #2 had no adaptive equipment or communication cards used during the meal.</p> <p>Staff #1 was interviewed on 2/26/16 at 11:48a.m. Staff #1 indicated clients #1 and #2 were to have high sided divided plates and built up handled utensils. Staff #1 indicated client #1 should also have had a non-skid mat under his plate. Staff #1 indicated client #2 also should have had a cuff on her hand to help support her spoon. staff #1 indicated client #2 should have been encouraged to feed herself.</p> <p>Record review for client #1 was done on 2/26/16 at 1:07p.m. Client #1's 8/19/15 individual support plan (ISP) indicated he was to use a divided plate on a non-skid pad and built up foam handled utensils.</p> <p>Record review for client #2 was done on 2/26/16 at 2:17p.m. Client #2's 8/19/15 ISP indicated she will hold her built up dining utensils in her hand with her feeding cuff on. The ISP indicated client</p>		<p>equipment to clients' Weekly site observations during meals and daily site observations in day services and other programming time will be done by one of the following, QIDP, Nurse, Coordinator or Director to ensure clients' adaptive equipment is available and being used Reports of the site visits are submitted for review by the leadership team weekly to address any concerns</p>	

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W 0488 Bldg. 00	<p>#2 will indicate eat and drink by pointing to her eat and drink cards.</p> <p>9-3-8(a)</p> <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 3 of 3 sampled clients (#1, #2, #3) and 3 additional clients (#4, #5, #6), the facility failed to encourage clients to participate in meal preparation and family style dining to the extent they were capable.</p> <p>Findings include:</p> <p>During the 2/25/16 observation from 4:14p.m. to 6:12p.m. and the 2/26/16 observation period between 6:14a.m. to 8:18a.m., at the group home, facility staff did not encourage clients, who were available and physically able to assist (#1, #2, #3, #4, #5, #6), to participate in all aspects of their meal set up and dining. On 2/25/16 at 4:42p.m. staff #7 put pot pies onto a cookie sheet. Staff also put condiments onto the dining room table, made buttered bread and put it onto the table, poured drinks for clients #2 and #3 and put salad dressing on client #3's</p>	W 0488	In response to W488, the facility failed to encourage clients to participate in meal preparation and family style dining to the extent they were capable, ASI identified that staff need additional training on ways to engage each consumer Training has been completed Weekly site observations during meals and other programming time will be done by one of the following, QIDP, Nurse, Coordinator or Director to ensure clients' adaptive equipment is available and being used Reports of the site visits are submitted for review by the leadership team weekly to address any concerns Site visits are made to the home 3 times a week and the Coordinator is in the home to observe at least one day a week. Site visit forms are submitted electronically to the team following the visit to immediately address any concerns. The leadership team reviews the site visits weekly as	03/31/2016

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	<p>salad. There were no napkins on the table and client #1 had food on his face with no verbal prompt to wipe his face. Client #4 ate his tossed salad with his fingers and was not offered a napkin.</p> <p>At 6:14a.m. the dining room table was set with plates, utensils and cups. Client #4 was the only client up at this time; he was in his bedroom. Staff #6 indicated staff had set the table. At 7:14a.m. the clients were at the dining room table to eat breakfast. Staff #4 poured clients #1 and #4's drinks. There were no napkins on the table. Client #3 had yogurt on her face throughout breakfast with no verbal prompt to wipe her mouth.</p> <p>Interview of staff #1 on 2/29/16 at 2:11p.m. indicated all of the clients were capable of assisting with the meal preparation and setting the table with some staff assistance. Staff #1 indicated the clients should have been more involved with the family style meal.</p> <p>9-3-8(a)</p>		part of quality assurance.		